

Association Health Plans

On June 19, 2018, the United States Department of Labor (DOL) issued a final rule widening access to association health insurance plans (AHP).ⁱ AHPs are health plans offered by small businesses and sole proprietors that allow groups to act as one large employer when offering health insurance to their employees. These arrangements are viewed as a way for small businesses and individuals to negotiate more affordable health insurance in a market that is viewed to favor larger groups.

AHPs have long been a common way to provide health insurance to employees of small businesses, members of trade associations, and even some individuals. Most AHPs are private arrangements that typically only allow members of the association to join, though some allow anyone to join for health insurance coverage.

The DOL rule allows more groups to form AHPs than what was allowed under the Patient Protection and Affordable Care Act (ACA). Under the relaxed rules, AHPs may be formed with the sole intent of providing health insurance benefits and to benefit from the advantages associated with the ACA law. Prior to the rule, AHPs were required to comply with the ACA's individual market requirements, which included protection for individuals with pre-existing conditions, out-of-pocket maximums, and an obligation to offer essential health benefits.¹

In response to the change, 11 states and the District of Columbia² filed a lawsuit challenging the new rule as a violation of the ACA.ⁱⁱ In the lawsuit, the states argue that the rule does not comply with ACA regarding the distinction between large employers, small employers, and individuals and that they do align with the DOL's definition of employer. They also argue that the rule increases the "risk of fraud and harm to consumers, requires states to redirect significant enforcement resources to curb those risks, and jeopardizes state efforts to protect their residents through stronger regulation."ⁱⁱⁱ As of February 2019, the lawsuit is still pending.

Background

Pre-ACA Regulatory Environment

A combination of federal and state laws guides the operation of AHPs. Through the Employee Retirement Income Security Act of 1974 (ERISA), federal law outlines the criteria by which

¹ Essential health benefits required under the ACA include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

² New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia, Washington, and Washington, D.C.

small employers and associations may form an AHP. State laws largely determine how AHPs may operate within each state, and states are able to financially regulate AHPs as well as regulate the coverage provided. As such, standards varied greatly from state to state.

Prior to the enactment of the ACA, AHPs were commonly formed by small employers and trade associations to provide health coverage to their employees. Such arrangements were popular among small employers because AHPs were viewed as a way to increase market power when negotiating health insurance contracts. AHPs were also a popular option among some associations and small businesses because they were not held to the same requirements as large group insurance plans.

AHPs were not required to meet the same standards as commercial insurance, such as filing requirements, underwriting restrictions, and solvency standards. They were also not required to cover essential health benefits and were allowed to operate business in one state but headquarter in another, typically a state with less regulatory oversight. Other requirements and restrictions were dependent on whether the association was a national or state association and whether policies were issued to the individual or to the association.

Post-ACA

Because of the inconsistency in oversight and standards associated with the health plans, AHPs also gave rise to fraud and insolvency. The ambiguous federal oversight of AHPs and the patchwork of state laws that guide their operation made AHPs an attractive vehicle for individuals wishing to sell fraudulent health plans. These plans would collect premiums from consumers for years and would subsequently fail to pay high-dollar claims, leaving the consumer with thousands in medical debt. In some cases, the association would fail to pay any claim. The lack of stringent requirements for AHPs also placed them at greater risk of insolvency when consumer claims exceeded their ability to pay.

To address the issues of fraud and insolvency associated with AHPs and to respond to concerns related to AHP's potential impact on the large-group market, in 2011 reforms were put in place to limit the growth of AHPs and increase consumer protections.

Under the ACA, policies sold through an association to individuals were required to comply with the law's individual market requirement. Plans sold to small employers were required to comply with the ACA's small group coverage requirements. Among the consumer protections put in place by the ACA that applied to AHPs were:

- a prohibition against denying coverage due to a pre-existing condition;
- rating rules that limit the factors insurers may use to charge some consumers more expensive premiums;
- a prohibition against annual and lifetime limits;
- guaranteed coverage of essential health benefits;
- 100 percent coverage of preventive services; and
- implementation of out-of-pocket maximums to reduce costs to the consumer.

The ACA also put in place additional reporting requirements and stronger enforcement authority for the DOL.

2018 Rule on Association Health Plans

While the June 2018 rule relieves AHPs of some ACA rules, the plans must still comply with certain requirements of the law. Under the new guidelines, AHPs continue to be prohibited from denying coverage or charging higher premiums based on an individual's pre-existing health condition. They are also held to ACA rules regarding annual out-of-pocket maximums, the prohibition on annual and lifetime benefit limits, and 100 percent coverage of preventive services.^{iv}

Under the rule significant changes were made to the interpretation of "employer" that broadens the criteria by which small employers and sole proprietors may form an AHP. The rule also regulates AHPs as large groups as defined by the ACA. According to the new rule:

- Employers can form an AHP based on common industry and geography by passing a "commonality of interest" test. In order to pass this test, an association must have members that share the same trade, industry, or profession or operate in the same state or within a common metropolitan area. Metropolitan areas may include more than one state.
- AHPs may be formed for the sole purpose of offering health insurance to its members.
- Sole proprietors and their families are now able join small business health plans. This provision allows self-employed individuals to be treated as an employee and allows coverage for their spouse and children.
- AHPs are not required to cover the 10 essential health benefits as required for large group insurance under the ACA.
- AHPs are also exempt from the ACA's rules on rating practices, which allows for premiums beyond the 3:1 ratio.³

³ The ACA prohibits insurers from charging older consumers rates that are more than three-times the rate for younger consumers.

Application of ACA Market Protections to Association Health Plans

	Under the ACA	New Guidance
Pre-Existing Condition Prohibition	✓	✓
Rating Rules	✓	x
Annual and Lifetime Limits	✓	✓
Coverage of Essential Health Benefits	✓	x
100% Coverage of Preventive Services	✓	x
Out-of-Pocket Maximums	✓	✓
Single-Risk Pool	✓	x
Risk Adjustment Program	✓	x

The Future of Association Health Plans

Currently, the new rule does not preempt state laws regarding AHPs. States may continue to restrict the way AHPs operate within their boundaries beyond what is outlined by federal law. The rule also does not affect existing AHPs, which must continue to comply with ACA requirements as outlined by previous guidance.

According to analysis by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), beginning in 2023 approximately 6 million additional people will enroll in either an AHP or short-term health plan, with approximately 4 million in an AHP and 2 million in a short-term health plan.^v The new rules governing short-term health plans and AHPs would result in 1 million fewer uninsured individuals by 2023 and each year thereafter.^{vi} The CBO and JCT also estimates that the vast majority of individuals projected to be insured by AHPs and short-term plans would have been insured without the new rules and that this population is likely to be healthier than the individuals in the ACA-compliant marketplace. These shifts in enrollment are projected to increase premiums in the individual market by 2 to 3 percent.^{vii}

Together with the expansion of short-term health plans and the temporary repeal of the individual shared payment responsibility, analysts predict that an increase in AHPs may lead to adverse selection in the insurance marketplace and destabilization of the ACA exchange. Some analysts speculate that an increase in AHPs may also lead to further market fragmentation in health care, which contributes to increased spending and inequalities in the quality of care.^{viii}

Proponents of expanded AHPs argue that the health plans reduce disparities between large and small business access to affordable health insurance coverage and that they expand options for consumers. AHPs are also touted as a way to reduce health care costs for consumers faced with

rising premiums in the ACA exchange. States across the country continue to experience a widening gap between advanced premium tax credit subsidized enrollees and those who are non-subsidized. Under the ACA, advance refundable tax credits are provided to consumers to reduce the cost of premiums. Consumers who do not qualify for these subsidies pay higher premiums and in recent years have experienced rising premium costs. In 2017, Missouri experienced a 31 percent decrease in non-subsidized enrollees.^{ix}

State laws will continue to shape the way the AHPs operate across the country. In Missouri, fully-insured group health plans are regulated by the Missouri Department of Insurance, Financial Institutions & Professional Registration. Self-insured plans are regulated through ERISA, not under Missouri law.

Efforts to mitigate any negative effects of the expansion of AHPs and other alternative health plans will likely be driven by state policy. As state policymakers and other stakeholders continue to explore ways to reduce health care related costs and strengthen consumer protections, further investigation into the effects of AHPs on state consumers and the state insurance marketplace is needed to fully assess the benefits and risks to Missouri consumers.

ⁱ 83 FR 28912 (<https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans>)

ⁱⁱ https://ag.ny.gov/sites/default/files/complaint_as-filed.pdf

ⁱⁱⁱ State of New York et. al v. United States Department of Labor, Case 1:18-cv-01747 (Civ. Action No. 18-1747)

^{iv} 29 C.F.R. 2510.3-5, as of Aug. 20, 2018

^v Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028, May 3, 2018, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>.

^{vi} Ibid.

^{vii} Ibid.

^{viii} “New Rules to Expand Association Health Plans.” The Actuary Magazine, 21 June 2018, <https://theactuarmagazine.org/new-rules-to-expand-association-health-plans/>.

^{ix} Centers for Medicare & Medicaid Services, “Health Insurance Market Enrollment Report” <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf>.